Elyon Healthcare Ltd

# Elyon Healthcare

## Inspection report

Gladstone Business Centre
Gladstone Road
Northampton
Northamptonshire
NN5 7QA

Tel: 01604600609

Date of inspection visit:
09 January 2018
11 January 2018

Date of publication:
04 April 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place between 9 and 24 January, with visits to the office on 9 and 11 January 2018 and was unannounced. This was the first comprehensive inspection carried out at Elyon Healthcare.

Elyon Healthcare is a domiciliary care agency providing personal care and treatment for disease or injury to adults and children. At the time of inspection they provided care for 18 people; five older persons, nine children, four of which had complex health needs and four younger adults.

Personal care is a regulated activity; CQC only inspects the service being received by people provided with 'personal care' living in their own homes or in specialist housing; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider Elyon Healthcare Ltd has one director, who is also the registered manager. The provider had a vision to build a service to meet the needs of three types of service users; children, young adults and older adults. In building the three areas of the service the provider had not ensured they had the systems and processes in place to assess, monitor and improve all areas of the quality and safety of the service. This service required improvements to ensure people received safe care.

The provider did not have oversight of the deployment of staff to meet older people's needs; as a result people did not always receive their allocated time for care. People were not given the time or opportunity to have all of their meals, prescribed medicines or personal care. The provider did not identify that older people were at risk of neglect due to the inadequate deployment of staff.

People could not be assured that they would always be protected from the risk of harm or poor practice. The provider did not have systems in place to identify issues that may indicate potential abuse; or then report any issues to all of the relevant authorities immediately.

Staff did not always ensure that older people received their medicines in a safe way. Although the provider had identified that people's medicines were not being safely managed they had not taken sufficient action to change staff practice to make people safe. We have made a recommendation about the use of emergency medicines.

People were at risk of not having their complaints responded to as not all information reached the right person to be recorded. Written information was not analysed for the potential for concerns or complaints. Where complaints had been recorded the provider had followed their procedures to manage people's

complaints.

Staff did not always understand their responsibilities under the Mental Capacity Act. The service needed to improve their existing culture to embrace the changes required to ensure people are treated with respect and working practices were carried out in line with the protected characteristics under the Equality Act. We have made a recommendation about advocacy for people who may need support to make decisions.

People were cared for by staff that had been employed using safe recruitment practices. Staff received training and supervision to support them in their roles.

People had risk assessments that were reviewed regularly; people received their care as planned to mitigate their assessed risks.

People's (adult) care was provided by staff that had received training and support to carry out their roles.

Children received care from staff that had the skills and competencies to provide their care; they were closely supervised by a paediatric nurse who supported staff in their roles.

Where people chose to stay at home as they approached the end of their life. Staff referred people to healthcare professionals for assessment and symptom control.

People were protected from the risk of infection by staff that complied with their infection prevention policy.

We made a recommendation about exploring  people's future wishes and priorities for care including care at end of life.

We made a recommendation about compliance with the Accessible Information Standard.

At this inspection we found that Elyon Healthcare were in breach of five regulations relating to the staffing, medicines, safeguarding, complaints and governance as the provider did not have sufficient systems and processes in place to ensure the quality and safety of the service.

This is the first time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

There were not always enough staff deployed to meet people's needs.

People did not always receive received their medicines as prescribed.

The provider did not have suitable systems in place to recognise, and record and report all potential safeguarding issues.

People could not be assured that staff continually learnt from incidents and improvements were made when things go wrong.

People's risks were assessed and reviewed regularly or as their needs changed.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures.

Staff followed procedures to help prevent and control infections.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always supported to eat and drink enough to maintain their health and well-being.

Staff did not always understand their responsibilities in relation to the Mental Capacity Act 2005.

People were cared for by staff that received the training and support they required to carry out their roles.

Children received care that was delivered in line with current legislation, standards and evidence based guidance.

Children were supported by staff that worked well across organisations to ensure safe admission, discharge and transfer of care.

## Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not have systems in place to ensure that all people received all of their commissioned care

People were mostly treated with kindness and respect by staff.

Families were supported to be involved in planning of their children's care.

People's privacy and dignity were maintained and respected.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have the opportunity to speak to staff when they wanted to make a complaint. Where complaints had been recorded, the provider had procedures they followed to manage and learn from complaints.

People were not supported to plan and make choices about their care at their end of life.

Older people did not always receive their care as planned.

Children and young adults received care that met their needs and had plans of care that were updated as their needs changed.

## Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have a clear strategy and vision to deliver high quality care to all people who used the service.

The provider did not have procedures in place to monitor the compliance and quality of the service or have systems in place to take action to improve where necessary.

People and their representatives were not always involved in developing the service.

There was a registered manager, however, they were absent for long periods of time.

# Elyon Healthcare

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced comprehensive inspection took place between 9 and 24 January 2018, the site visits to the office took place on 9 and 11 January 2018. The inspection was carried out by one inspector. This was the first comprehensive inspection since the location registered with CQC in December 2016.

We contacted the health and social care commissioners who monitor the care and support of adults receiving care from Elyon Healthcare who shared the information from their quality monitoring visit in October 2017.

We also spoke with two health and social care professionals who commissioned services for children; they shared information about the service from their contract monitoring of Elyon Healthcare.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with three relatives of people using the service. Most people were not able to speak due to their young age or medical conditions. We also spoke with seven members of staff including the registered manager, the manager, a children's nurse, a team leader, a care co-ordinator and two care staff.

We looked at the care records for 11 people who used the service; this included four older adults and three young adults with a learning disability who received personal care, and four children who had complex needs. We also examined other records relating to the management and running of the service. These

included six staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, complaints, incidents and accident reports and quality monitoring audits.

Requires Improvement

# Is the service safe?

## Our findings

There were not always enough staff deployed to provide people's care. People (adults who used the service) did not always receive their care at agreed times or for their full allocation of time. The planning of the rotas did not allow for travel time and did not have a logical route as staff travelled back and forth across the town. Staff recorded when they arrived and left people's homes; the records showed that people regularly had very early or late calls. For example of the 60 completed calls we viewed on the rota system in January 2018, 26 of these calls were provided more than 30 minutes earlier or later than scheduled. This meant that people received their calls too close together or too far apart which affected the times of their personal care, meals and medicines. For example two people were at risk of experiencing pain as they did not have the opportunity to have regular pain relief as their calls were too close together to receive all their possible doses of prescribed Paracetamol. We brought this to the attention of the manager who immediately changed the rotas to include travel time and regular timeslots to allow for people to have regularly spaced care.

The provider did not ensure that people received all of their commissioned care. The provider did not ensure staff provided care for the allocated time. For the 60 calls we viewed in January 2018, 72 hours of care had been commissioned; only 31 hours of care was recorded as being provided. The shortest call was two minutes out of the allocated 30 minutes, not enough time to provide personal care, a meal and medicines. This person was recorded as only received 24% of their allocated time over four days and was at risk of skin problems due to soiled clothing. We brought this to the attention of the manager who spoke with all the staff concerned to reiterate the length of calls each person should receive. Throughout the inspection we continued to monitor the timings of people's calls; these had improved so that people were receiving their calls at the allocated times but we have not been able to test whether these had been embedded into practice.

The provider did not have systems in place to monitor the rotas to ensure that people received all of their allocated calls. One relative told us their relative had not received all of their calls and they had not always been informed in advance, they told us "I suppose they have problems if staff drop out."

People did not always have staff with skills that met their needs. One young adult relied on staff to drive their Motability car to go out, however, the rotas showed that not all staff could drive. Their relative told us "There are only two staff that can drive; it means [name] is isolated in the house, it limits [name's] quality of life. They [Elyon Healthcare] are still looking for staff; we have plenty of new staff shadow the regular staff but they never come back." This person did not always get all of their allocated care. Their relative told us "On one occasion no-one turned up, I phoned, they looked into it but they could not find anyone to provide the care."

The provider did not ensure that staff had enough rest and recuperation between their shifts to enable them to provide safe care. Staff who cared for children with complex needs did not have sufficient breaks between shifts to be rested enough to provide safe care. For example one member of staff looked after a child with complex medical needs for five nights; in the daytime between these night shifts they provided care for three

other children. Their rota also showed during the day the member of staff also received their annual training and supervision. We brought this to the attention of the manager who reviewed people's rotas and put in place a guideline to ensure that staff have at least 10 hours break between shifts. We have not been able to assess whether this has been embedded into practice.

The provider did not ensure there were always enough staff to provide care to children. Not all of the commissioned hours had been allocated to staff. For example, one child required day and night care. The child received their care at night from a regular team of staff, but the provider had not been able to recruit suitable staff to provide their care during the day. The commissioners were aware of this when the service was first commissioned. The family were informed and agreed to provide some care themselves. At other times when there were not enough staff to provide children's care; the provider had informed parents in advance that they could not provide staff for particular allocated calls. Where staff were not available parents provided the care. One social worker told us "There are times when they [allocated calls] are not fulfilled, they [Elyon] try and cover them, the parents cover when they [Elyon] cannot manage it."

The provider did not always inform parents of changes to rotas. Children's parents received rotas showing which staff had been allocated to provide their child's care. Staff provided children's care mostly at the times allocated; however, some staff were persistently over 30 minutes late. Parents' told us they were generally happy with the rotas, except when changes to staff were made. One parent told us "They never tell us if they have changed the staff, sometimes we have someone we are not expecting arrive."

The provider did not ensure that there were enough staff deployed to meet people's needs. This constitutes a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Staffing.

People (adults) could not always be sure they would receive their medicines as prescribed. Staff were not allocated to provide care for people at a time that they required their medicines. For example one person was prescribed morphine every 12 hours but staff were allocated to provide their medicines at around 8.45am and 6pm every day. This meant that they received their morphine nine hours and 13 hours apart. This person was at risk of the effects of not receiving morphine at the prescribed times including experiencing pain overnight. We brought this to the attention of the manager who changed the rotas to enable staff to provide their medicines as prescribed. We have not been able to assess whether this has been embedded into practice.

Staff did not have suitable knowledge and skills to manage people's medicines safely as there was no reliable record of the medicines people received. Although staff had received training in the administration of medicines, they had not received adequate supervision or their competencies checked to ensure they were safe to administer medicines. Staff had been trained to record on people's MAR charts when they had administered people's medicines; however people's MAR charts were not reliably completed. Where there were gaps in people's MAR charts, staff did not report this to the provider or check that people had received their medicines. People were at risk of not receiving their prescribed medicines as staff did not follow procedures and there was no system in place to supervise medicines administration.

The managers carried out regular audits of people's Medicine Administration Record (MAR) charts. The audits had not identified that the medicines were not always administered at the prescribed times or that staff did not reliably record the medicines that had been administered. For example one person required a morphine patch to be administered every 72 hours. Staff had recorded on their MAR chart that the patch had been given daily for six days and not administered for the next 12 days. There was no indication of

where on the body the patch had been administered or how many patches were left. This person's health was at risk due to the effects of too much morphine and being in pain when the morphine had not been administered. We raised a safeguarding alert in relation to the unsafe administration and recording of this medicine.

The provider did not ensure that there were systems in place for the proper and safe management of medicines. This constitutes a breach of Regulation 12 (2g) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Safe care and treatment.

There were suitable systems in place for the safe management of medicines to children. A paediatric nurse managed the information about each child's medicines and ensured that their MAR charts reflected their prescribed medicines. Staff that administered medicines to children had received training in the management of medicines, such as the administration of nebulisers and oxygen and their competencies were checked regularly by a paediatric nurse.

People were not always protected from harm because there had not always been suitable systems and processes in place to recognise and report the risks and signs of abuse and neglect.

The service did have a system in place for people, their relatives and staff to contact the staff member on call. However, it was not suitable and people and staff commented that they often could not get through. There was an on-call system where a member of staff was allocated to respond to people's calls; however, there were no reliable records of the concerns raised to the on-call staff or the actions that had been taken. Staff told us they were not always able to speak to the person on-call, one member of staff told us "It's hard to get through to the office." people were at risk of not having their concerns escalated to the appropriate management team or agencies as there due to the system in place to record or respond to concerns.

Where staff had reported incidents that may indicate abuse office staff had not always followed the correct safeguarding procedures. For example staff had reported unexplained bruising; office staff informed the child's social worker. All safeguarding concerns must be made to the relevant safeguarding teams for assessment; office staff had not followed safeguarding procedures.

Where safeguarding alerts had been raised, the investigations had been hampered by lack of records due to key staff leaving without concluding the investigation. The provider had failed to ensure there were adequate systems in place to investigate safeguarding alerts.

The provider did not recognise that five people were at risk of neglect due to the poor deployment of staff. People were at risk of not receiving regular meals, personal care or their medicines at suitable times to maintain their health and well-being. Although some of the staff recorded that one person regularly refused personal care there were no safeguarding alerts raised in relation to their risk of self-neglect.

The provider did not ensure that there were systems in place to prevent or report abuse or improper treatment. This constitutes a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The provider did not have all the systems in place to make improvements to the service. Monthly management meetings were held to discuss risks, training, safeguarding, complaints and audits. Not all subjects were discussed at all meetings. Where issues had been identified, actions had not always been carried out, for example the monthly minutes recorded there was "a lack of continuity between audits and

no regard to previous recommendations." This had led to staff re-doing audits.

The provider followed safe recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Where people required visas to work in the United Kingdom these had been acquired. Nursing staff provided evidence of their registration with the Nursing and Midwifery Council (NMC) and the provider had systems in place to ensure their registration was maintained.

People's (Adults) risks were assessed and reviewed regularly, for example moving and handling or their risk of falls. Risk assessments reflected people's current needs and staff were provided with clear instructions in care plans to mitigate the assessed risks. For example one person's mobility needs changed daily, staff followed the care plans to use a rota stand or a hoist when the person needed additional assistance.

Children's risk assessments were carried out regularly or as their needs changed. Each child had risk assessments in place which included clear guidelines on how staff were to mitigate the risks. Records showed and staff told us how they ensured each child received the care they needed to mitigate each known risk. For example, where children were at risk of low oxygen levels, risk assessments were in place and staff followed care plans to monitor children's oxygen levels; staff followed guidelines to provide oxygen and suction when required.

People were protected from the risks of infection as the provider had infection control procedures that staff followed. Staff wore personal protective equipment such as gloves and aprons when providing personal care. Staff completed training in infection prevention and their competencies were checked.

Requires Improvement

# Is the service effective?

## Our findings

People (adults) were not always supported to eat and drink enough to maintain a balanced diet. Staff were allocated to people at irregular times to provide all of the meals. People were provided with their meals at irregular intervals and staff did not always stay for the time allocated. For example the rotas showed that one person had their breakfast at 9am and their lunch at 11am, their evening meal was provided at around 6pm. This person was at risk of not being able to eat their lunch as they had just received their breakfast and then waited for seven hours for their evening meal. Staff were instructed to sit with another the person whilst they ate their meal; however, the records showed that staff only stayed at the person's home between two minutes and 16 minutes at a time, an insufficient time to support the person with their meal. These people were at risk of not maintaining their health or well-being as they were not receiving regular meals. We brought this to the attention of the manager who changed the rotas to allow people regular times for their meals; we have not been able to assess whether the rotas have been embedded into practice.

The provider did not ensure that there were enough staff deployed to meet people's needs. This constitutes a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Staffing.

People were assessed for their risks of choking. Where people had been assessed by health professionals as requiring softer foods, or food that had been cut into small pieces, staff followed these instructions to provide food that was suitable for their needs.

Where people required their food via a percutaneous endoscopic gastrostomy (PEG) tube staff had received training in providing their nutrition and water safely. Records showed that people received their PEG feeds as prescribed. Staff monitored the site of the PEG tube and ensured this was kept clean, following the provider's procedures and protocols.

People (Adults) received care from staff that had the skills and knowledge to meet their needs. All new staff had an induction where they completed the Care Certificate which included training in core areas such as health and safety, moving and handling, infection control, nutrition, basic life support and safeguarding of vulnerable adults. New staff received close supervision and shadowed more experienced staff and were assessed for their suitability and competency during their probation.

People (Adults) had access to healthcare services and received on-going healthcare support and staff referred people for medical care promptly when people became unwell.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as less restrictive as possible. People (adults) had been assessed for their mental capacity to make informed decisions about their care. However, one person had fluctuating capacity due to their health condition and had been

refusing care.

We recommend that the provider consults with health professionals for MCA assessment and best interests for people with fluctuating mental capacity.

Children's care needs were assessed before receiving care to establish if the service could support their needs. There was a paediatric clinical lead and a paediatric nurse employed to oversee children's care. One paediatric nurse told us "We receive the information from the commissioners; we then meet the family and carry out a full assessment of their child's needs." Four children had been assessed as having complex care needs such as care of epilepsy, tracheostomy, seizure management or PEG care. Four children required care that included managing behaviour that challenged others. All children's care was overseen by the two paediatric nurses. There were standards and guidelines in place to manage their nursing needs which were evidence based. Protocols and procedures such as the care of tracheostomy tubes, PEG tubes and oxygen were developed in line with best practice within the NHS.

Children received care from staff that had received training specifically for each child's needs. Staff were trained and closely supervised by a paediatric nurse who used an evidence based competency framework to assess and test staff knowledge and skills. For example where children required care of their airways including suction, staff received training to manage this. Some staff received training from health professionals in hospitals. One member of staff told us "I went to the hospital where [name of child] was before they were discharged. I had a lot of supervision, learning how to care for [name's] tracheostomy."

Staff providing care to children received supervision and support to carry out their roles; they had frequent spot checks and supervision to assess their confidence and competence. Staff could call upon the nursing staff for assistance. One member of staff told us "I was worried one evening, so I called the nurse who came and worked the shift with me. It really helped my confidence." The nurse told us "[Name of staff] told me [Name of child] had a new spasm; I went to the home and established there was no cause for concern, I worked the rest of the shift to provide support." There were systems in place to provide on-going support to staff and they confirmed they received regular formal supervision.

Staff monitored children's clinical observations and report any changes to the paediatric nurse and the parents. Staff had guidelines of the normal observations for each child to help recognise when a child was unwell. Medical advice was sought where required. One family asked for and received assistance for their child to attend healthcare appointments. Where children were admitted to hospital staff continued to provide care for the first day of their admission and the last day in hospital before they were discharged to ensure there is a complete handover of care.

Requires Improvement

# Is the service caring?

## Our findings

People (adults) did not always receive care that was considerate as staff did not always help to maintain people's psychological well-being. Although they received care from staff that they knew, staff had not spent time with people to talk with them during their allocated time. For example one older person who lived alone had their care reviewed in December 2017; they had expressed at the time they had felt lonely. This person was allocated four visits a day for a total of 150 minutes of care. Records showed that they did not receive the whole time allocated to them; in the week beginning 4 January 2018 records showed they received less than half of their allocated care every day. This person could have spent time with staff during their allocated times which could have helped to relieve their sense of loneliness.

Another older person lived alone; they required support with their personal care, meals and medicines. Their records showed they were prone to being low in mood as they tried to adjust to their changing reliance on receiving care. However over four days in January 2018 staff provided less than a third of their 90 minutes of allocated care. Staff had not spent time with this person even though they had the allocated time to do so.

Where people lived with their families, staff had not spent time building relationships. However, they did tell us that most staff were kind. One person's relatives told us "Staff are mostly polite and kind." Another relative said "The relationship with staff is alright, they usually get on well with [Name]."

People's privacy and dignity were respected. One person's relative said "They keep [Name's] dignity, they're very good." Another relative told us "[Name] cannot move by themselves; staff are kind and tell [Name] what they are doing."

The provider did not always record if people had a Lasting Power of Attorney (LPA) to advocate for them during their reviews. People did not have information about referral to an independent advocate if they felt they were being discriminated against under the Equality Act. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

We recommend that the provider sources suitable information about advocacy for people who may need support to make decisions.

Staff had detailed information on how children and adults who could not communicate verbally expressed themselves. Their care plans showed how people expressed happiness and discomfort. However, young adults who had communication difficulties did not have all of their communication needs met as they were relatively new to the service. The manager who had experience in communicating with young people with learning disabilities was developing a way of communicating with one person by taking photographs of objects they used and places they liked to go for them to refer to.

Children receiving care, and their families, received care from staff that had taken the time to get to know them. Where new staff were introduced they worked with the paediatric nurse to get to know them. Families had regular contact with the paediatric nurse; the nurse told us "I love my families. I contact them every

week, if they've had a rough night I call them to see if they are OK."

One family held charity events to help raise funds for their child's equipment. The paediatric nurse described how they attended these events to support the family; they told us "It's a privilege to support them."

The manager introduced picture prompts for one child to help them to cope with their routine. They told us "It has made a big difference; it has had a good impact at home and school." Records showed that this child's behaviour had improved since the introduction of the pictures.

When people could not communicate their needs, staff ensured that people's likes and dislikes were known. For example, staff were aware of children's routines that helped them to feel secure. Records showed that staff carried out children's care that reflected their likes and dislikes through their choice of music, singing and play. Staff were able to tell us in detail how they provided care and how they communicate with each child. One member of staff told us "[Name] communicates through their eyes; I can tell if they are relaxed."

We recommend that the provider explores how they will comply with the Accessible Information Standard.

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance and staff were provided with training about the importance of confidentiality. Information about people was shared on a need to know basis. We saw that people's files were kept secure in filing cabinets and computers were password protected to ensure that information about people complied with the Data Protection Act.

Requires Improvement

# Is the service responsive?

## Our findings

People did not feel confident that their complaints would be responded to. People told us that the communication with Elyon Healthcare staff was poor, that when they called the office they often could not get through to talk to someone about their concern. One person's relative told us "When you do eventually speak to someone, they say they are going to do something but they don't." The complaints log showed there had been some complaints, but no complaint had been recorded regarding this person. The provider had recorded in their team meeting in October 2017 that staff did not always record people's concerns and set an action to create a complaints template for office staff to complete. However this was never completed or followed up by the provider.

There was a complaints process in place. One relative told us "I've not had to make a complaint but I would phone the office and follow this up in writing if I had any concerns. In general I will phone up and try and sort things out that way." Where people had their complaint recorded it had been dealt with according to the provider's policy. Points for learning were shared with staff at team meetings to help prevent future complaints; however these were limited due to the lack of recording of all complaints.

The provider did not have sufficient systems in place to record or respond to complaints. This constitutes a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Receiving and acting on complaints.

People did not always receive care that met their preferences. The provider had not ensured that staff had been allocated to them in line with their preferred times. There was no system in place to allocate staff to people's preferred times. People received care at different times each day, leaving some people waiting for care and others being helped to bed early. For example one person was allocated a half hour call in the evening at 7.30pm; the records showed they actually received their care at 6.10pm. Another person preferred female care staff. Records showed that they had been allocated male staff. This had led to a complaint where the family had to provide their personal care as male staff had been allocated to them.

Although people (adults) had comprehensive care plans that provided staff with detailed information of how to care for them, people did not always receive all their care as planned. For example one person required personal care to help prevent any problems with their skin. Records showed that they had not received their personal care as they had not been encouraged to clean their teeth, change clothing or supported to have a bath. This person was at risk of neglect due to the lack of care. We brought this to the attention of the manager who arranged for a specific member of staff to provide their care to try and build a relationship with this person to help them feel comfortable about their care. We have been unable to assess the effectiveness of this.

People's care plans gave staff clear instructions on how to mobilise people safely. For example one person had fluctuating mobility needs; staff followed the care plans that advised them how to support the person to use their hoist or rotund stand when transferring from bed to chair.

People were assisted to receive their care for specific social occasions, for example one person liked to have their hair styled on a specific day; care staff ensured she was in her wheelchair so she could be ready for her haircut.

The service did not have any service users who had been identified as being in the last 12 months of life and therefore discussing end of life care was not appropriate at his time.

We recommend that the provider finds a reputable resource for training and implementing ways of having conversations with people, their families and carers and those looking after them about their future wishes and priorities for care.

Children received their care as planned. Their care plans were very detailed and provided specific instructions for staff to follow. Staff received close supervision by a paediatric nurse to learn all the skills required to look after each child. Once staff had their competencies for every area of care they could provide care for a child alone. Staff recorded the care they provided every hour, directly onto the computer system which was available to the paediatric nurse.

Staff had clear guidelines on how to provide care safely. For example monitoring children's' oxygen levels and managing their care to maintain safe levels. Children's' skin was checked regularly where the oxygen saturation probe was placed and staff followed care plans that stated that the site of the oxygen probe had to be changed regularly. Staff helped children to change positions, clear airways by using suction and giving medicines via a nebuliser. Staff recorded their actions and the outcomes. One parent had told Elyon Healthcare at their last review in January 2018 "I'm happy with the service."

Children who experienced seizures received care from staff that understood how to monitor each seizure and know when to call for assistance. Parents were involved in the care planning for their children. Their views were sought in relation to the administration of medication with their responses documented clearly within the care plan. Some parents expressed a wish to administer their child's medication and the staff were respectful of this wish.

We recommend that Elyon Healthcare clarify the requirements of the commissioners regarding the administration of emergency medicines for the treatment of seizures.

Staff followed clear instructions on the care of children's tracheostomy tubes and feeding tubes ensuring they were patent and used according to the guidelines. Children who required their feeds received these as planned; staff positioned children safely to receive their feeds and had clear instructions to watch children look out for signs of aspiration.

Children's pressure areas were protected by staff that followed care plans that instructed them to support children to move regularly and support them with equipment such as cushions.

Children's parents and social workers were involved with their care planning. Elyon Healthcare staff ensured that all the information about children's care and progress was documented so the multi-disciplinary team could make informed decisions about their care.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager who had managed Elyon Healthcare since the service registered in December 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had notified CQC they had been previously absent for over a month in October 2017. The registered manager was not present at the time of inspection as they were out of the country; we contacted them on their return, a week after the inspection. The registered manager told us they had other absences planned for 2018. Due to the nature of the breaches and the issues found during this inspection we expressed our concerns that the service did not have a registered person who was responsible for the management of the service available at all times. The registered manager told us they planned to register another person.

In the absence of the registered manager, there was a general manager who had been appointed to manage the service. The general manager was an experienced person who had the skills and knowledge to manage the service. The children's management team had been fully recruited but was in its' infancy. However, the service did not have all of the systems and processes in place to enable the staff to provide care to meet all of people's (adults) needs safely. The general manager had implemented some systems but some decisions that required the registered manager's input were delayed due to their absence.

There was a lack of embedded systems and processes in key areas of the service which had an impact on people's (adults) safe care. The registered manager had not ensured that staff allocations, safeguarding processes, audits of medicines and rotas, or clear communication for out of hour's assistance had been established enough to be effective or self-regulating. Where audits had identified issues, these had not been resolved as further audits demonstrated that the issues remained. This meant that people continued to be at risk of not receiving their prescribed medicines.

There was a lack of quality monitoring of the allocation of staff; how long they stayed at each call and what care had been carried out. This had resulted in older people not receiving all of their allocated time, or receiving care at inappropriate times.

There was a lack of monitoring or oversight of the allocation of staff to the child service users; as staff were allocated to night and day shift concurrently without a suitable period of rest and recuperation. This put children at risk receiving care from staff that are not able to concentrate enough to provide safe care.

The provider did not have systems and processes in place to assess, monitor and improve the safety and quality of the service. This constitutes a breach of Regulation 17 (2a and f) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Good governance.

The registered manager understood and carried out their role of reporting incidents to CQC. However, there had been delays in reporting some incidents to CQC after they had been reported to other agencies.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure the safe and proper management of medicines. Regulation 12 (2g) |

| Regulated activity | Regulation |
|---|---|
| Personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider did not have systems in place to recognise record or report potential abuse. Regulation 13 (2 and 3) |

| Regulated activity | Regulation |
|---|---|
| Personal care<br><br>Treatment of disease, disorder or injury | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider did not have sufficient systems in place to capture, record or respond to all complaints. Regulation 16 (2) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have sufficient systems in place to assess, monitor and improve the quality and safety service. Regulation 17 (2a and f) |

**The enforcement action we took:**

We issued a Warning Notice to require the provider to be compliant with Regulation 17 by 19 March 2018

| Regulated activity | Regulation |
|---|---|
| Personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not ensure there were enough suitably skilled staff deployed to meet people's needs. Regulation 18 (1) |

**The enforcement action we took:**

We issued a Warning Notice to require the provider to be compliant with Regulation 18 by 19 March 2018